

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23083

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1672

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>4020</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Bellefontaine Neighbors</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Bellefontaine Neighbors</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>9218 Astoria Drive</b>		d. STREET ADDRESS (If rural, give location) <b>9218 Astoria Drive</b>	

3. NAME OF DECEASED (Type or Print) <b>RAYMOND</b>		a. (First) <b>J</b>	b. (Middle)	c. (Last) <b>BUCHER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 20, 1952</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Sept 2, 1904</b>	9. AGE (In years last birthday) <b>47</b>	10. IF UNDER 1 YEAR Page <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Granulator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grove Lab. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>George Bucher</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Hoffmeister</b>		14. NAME OF HUSBAND OR WIFE <b>Single</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>489-09-9424</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Miss Alice Bucher</b>		ADDRESS <b>9218 Astoria Dr</b>	
---	---	---	--	-----------------------------------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Ruptured Aortic Aneurysm</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Lues.</b>			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>5</b>	19b. MAJOR FINDINGS OF OPERATION <b>022X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1942, to June, 1952, that I last saw the deceased alive on June 19, 1952, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>William O. Mowsey M.D.</b>	23b. ADDRESS <b>3625 Fair One</b>	23c. DATE SIGNED <b>6/20/52</b>
---	--------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Jun 23 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
--	---------------------------------	---	---

DATE REC'D BY LOCAL REG. <b>6-20-52</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Domb</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>4746</b>	ADDRESS <b>Bromschwig and Son W Florissant</b>
--	---	---	---

